Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
10002 BATTLEVIEW PKWY
MANASSAS VA 20109-2332

Respondent Name
ACE AMERICAN INSURANCE COMPANY

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-09-0118-01

MFDR Date Received
August 25, 2008

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Based on the Stop Loss equation under Rule 134.401(c)(6), We pray for an additional payment of $57,860.25"

Amount in Dispute: $57,860.25

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Requestor asserts it is entitled to reimbursement in the amount of at least 75% of the total charges. Requestor has not shown entitlement to this alternative, exceptional method of calculating reimbursement and has not otherwise properly calculated the audited charges. . . . There is no evidence submitted by the hospital demonstrating that the services provided by the hospital were unusually extensive. . . . Secondly, there is no evidence that the services provided by the hospital were unusually costly to the hospital. . . . Using the per diem method, a 5 day surgical admission qualifies for $5590 ($1,118 * 5 days) in reimbursement. . . . Further, the Requestor is entitled to reimbursement for implantables (revenue codes 275, 276 and 278) and orthotics/prosthetics (revenue code 274) in a fair and reasonable amount. The carrier would suggest that the hospital's cost plus 10% would be fair and reasonable. . . . The Requestor may also be entitled to additional reimbursement for pharmaceuticals costing in excess of $250 per dose. The Requestor must document the cost of such pharmaceuticals so Carrier may reimburse at cost plus 10%."

Response Submitted by: Flahive, Ogden & Latson, 504 Lavaca, Suite 1000, Austin, Texas 78701

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
October 12, 2007 to October 17, 2007	Inpatient Hospital Services	$57,860.25	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedures for requesting review by an Independent Review Organization (IRO).
4. 28 Texas Administrative Code §134.401 sets out the fee guideline for acute care inpatient hospital services.
5. 28 Texas Administrative Code §134.1 provides for fair and reasonable reimbursement of health care in the absence of an applicable fee guideline.
6. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
7. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 147 – Provider contracted/negotiated rate expired or not on file.
   - W1 – Workers Compensation State Fee Schedule Adjustment
     - $0.00
     - $8,250.00
   - 50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer. $0.00
   - 205 – Pharmacy discount card processing fee $0.00
   - 873 – REIMBURSEMENT NOT RECOMMENDED; SERVICE(S), ITEM(S) NOT MEDICALLY NECESSARY FOR REMEDIAL TREATMENT OF THE WORK RELATE INJURY/ILLNESS $0.00
   - 877-999 – REPORT NECESSARY FOR REIMBURSEMENT. PLEASE RESUBMIT WITH APPROPRIATE REPORT. $0.00
   - 885-999 – REVIEW OF THIS CODE HAS RESULTED IN AN ADJUSTED REIMBURSEMENT OF
     - $0.00
     - $8,250.00
   - 900 – BASED ON FURTHER REVIEW, NO ADDITIONAL ALLOWANCE IS WARRANTED.
   - 975-640 – NURSE REVIEW IN-PATIENT HOSPITAL/FACILITY/SUPPLY HOUSE
   - 981- REVIEWED BY MEDICAL DIRECTOR.
   - W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Findings

1. The insurance carrier denied disputed cardiology services billed under revenue code 480 with reason codes 50 – "These are non-covered services because this is not deemed a 'medical necessity' by the payer. $0.00" and 873 – "REIMBURSEMENT NOT RECOMMENDED; SERVICE(S), ITEM(S) NOT MEDICALLY NECESSARY FOR REMEDIAL TREATMENT OF THE WORK RELATE INJURY/ILLNESS $0.00." 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee for health care determined to be medically necessary and appropriate for treatment of that employee's compensable injury. §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021." The appropriate dispute process for unresolved issues of medical necessity requires the filing of a request for review by an Independent Review Organization (IRO) pursuant to 28 Texas Administrative Code §133.308 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of medical necessity with regard to the disputed cardiology services billed under revenue code 480. No documentation was submitted to support that the issue(s) of medical necessity have been resolved prior to the filing of the request for medical fee dispute resolution. The Division concludes that the requestor has failed to support that the cardiology services billed under revenue code 480 are eligible for medical fee dispute resolution. Therefore, these services will not be considered in this review.
2. This dispute relates to inpatient hospital services with reimbursement subject to the provisions of former 28 Texas Administrative Code §134.401(c)(5)(A), which requires that when "Trauma (ICD-9 codes 800.0-959.50)" diagnosis codes are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Review of box 67 on the hospital bill finds that the principle diagnosis code is listed as 813.32. The Division therefore determines that this inpatient admission shall be reimbursed at a fair and reasonable rate pursuant to Division rule at 28 Texas Administrative Code §134.1 and Texas Labor Code §413.011(d).
3. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 *Texas Register* 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that "Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures

that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available."

4. 28 Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective May 25, 2008, 33 *Texas Register* 3954, applicable to requests filed on or after May 25, 2008, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable." Review of the submitted documentation finds that:

   - The requestor's position statement asserts that "Based on the Stop Loss equation under Rule 134.401(c)(6), We pray for an additional payment of $57,860.25"
   - The Division's former *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.401 is not applicable to the services in dispute. Per §134.401(c)(5)(A), when ICD-9 codes 800.0-959.50 are listed as the primary diagnosis, reimbursement for the entire admission shall be at a fair and reasonable rate. Therefore, the applicable rule for reimbursement is found under §134.1(d).
   - The requestor asks for reimbursement under the stop-loss provision found in former 28 Texas Administrative Code §134.401(c)(6). However, §134.401(c)(6) states that "The diagnosis codes specified in paragraph (5) of this subsection are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate." As stated above, the Division has found that the primary diagnosis is a diagnosis code specified in §134.401(c)(5); therefore, the disputed services are exempt from the stop-loss methodology and the entire admission shall be reimbursed at a fair and reasonable rate pursuant to §134.1.
   - The Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital's billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division's former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 *Texas Register* 6276 that:

     > "A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources."

     Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
   - The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
   - The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
   - The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

   The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

	Grayson Richardson	December 27, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.